Capital Physical Therapy

Name: ______________________________ DOB: ___/___/______ Today's Date: ___/___/_________

Occupation: __________________________ Gender: M F PCP: __________________________

Referring Physician (MD):________________________ Next appointment w/ referring MD: ___/___/___

Please answer the following questions:

What injury or condition brings you here today? ____

When did you first notice your condition (date of onset)? ____

How did this injury occur? ____

Is your condition due to a motor vehicle accident? Yes No If yes, date of accident? _______________

Have you had any falls in the past 12 months? Yes No If yes, how many times? _______________

Did the fall(s) result in injury? Yes No If yes, please describe: _______________

Please describe above: ____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, etc.)? Please list: ____

Have you been treated by another physical therapist in the past for this or any other condition? Yes No

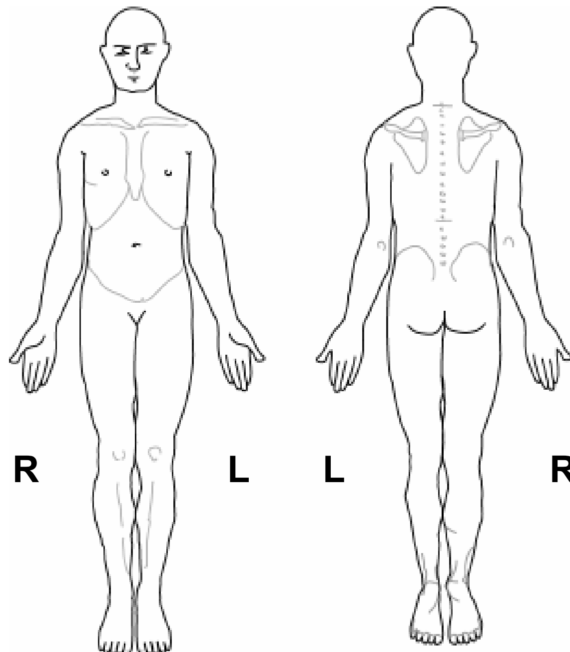
If Yes, by whom/when? ____

What tests have you had for this condition? X-ray MRI CT scan Other: _______________

Please mark where you have symptoms on the picture below. Also mark any areas of numbness/tingling or other unusual sensations:

Please circle/describe your symptoms:

- Constant (24 hours/day)
- Intermittent (comes and goes)
- Knife-like/ Sharp
- Burning
- Pins and Needles
- Dull
- Numbness
- Aching
- Throbbing
- Other: _______________



Please circle the numbers that best correspond with your pain level at its BEST and its WORST (e.g. 3 and 8):

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain, annoying		Nagging		Miserable, distressing		Intense, dreadful		Unimaginable

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Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in the: morning afternoon night same all day

What are your goals for physical therapy? ____

Please list past surgeries/conditions/hospitalizations:

_______________________________________ ______/_______/______________

_______________________________________ ______/_______/______________

_______________________________________ ______/_______/______________

_______________________________________ ______/_______/______________

Please list all medications, reason for taking and dosages (or you may attach a separate list):

____ Dosage:______________

____ Dosage:______________

____ Dosage:______________

____ Dosage:______________

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

High Blood Pressure	Depression	Breathing Difficulties/ Asthma
Rheumatoid Arthritis	Cancer	Frequent Falls
Diabetes	Dizziness	Thyroid Problems
Osteoporosis	Bowel or Bladder Problems	Headaches
Heart Problems	Multiple Sclerosis	Stroke
Seizures	HIV/AIDS	Blood/clotting disorders
Kidney Problems	Hepatitis / Tuberculosis	Other: __________

Do you have a Pacemaker/Defibrillator? Yes No

For women: Are you pregnant? Yes No

Please list any allergies that you have (For example: medications, latex, food, bee stings): __________

Is there any additional information? ____

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The above information is true to the best of my knowledge.

Signature: ____ Date: ___/___/_________